Print Reset Form

Instructions for Completion

GROUP SELF-INSURERS' NOTICE OF ACCEPTANCE OF MEMBERSHIP

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
P.O. Box 30016, Lansing, Michigan 48909

Reinstatement: ☐
Date of Prior Termination: _____

INSTRUCTIONS: SEE REVERSE SIDE

1. Employer Federal ID Number	2. Name of Business(es)
Click Here to Start	

3. Owner of Business (if applicable)			
4. Business Address (Street Number and Name)	City	State	ZIP Code

5. Type of Organization

☐ a. Corporation ☐ c. Individual ☐ e. Joint Venture
☐ b. Partnership ☐ d. Public Employer ☐ f. Limited Liability Company

6. Self-Insured ID Number	7. Name of Group Fund		
8. Effective Date of Coverage	9. Annual Payroll in Dollars $	10. Michigan Class Code	11. Number of Employees

Pursuant to the Workers' Disability Compensation Act, this is to certify that the above referenced employer has been accepted as a member into a self-insurers' group. The group self-insurer agrees to cover all liability imposed upon that employer by the provisions of the Michigan Workers' Disability Compensation Act.

12. Signature of Administrator or Trustee	Date

13. Please list below additional names and/or addresses for the Federal ID Number listed in item #1.

Name of Business			Name of Business		
Address (Street No. and Name)			Address (Street No. and Name)		
City	State	ZIP Code	City	State	ZIP Code
Name of Business			Name of Business		
Address (Street No. and Name)			Address (Street No. and Name)		
City	State	ZIP Code	City	State	ZIP Code

WC-650 (Rev. 5/04) FRONT

The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Purpose of Form WC-650:

To notify the Michigan Workers' Compensation Agency that an employer has become a member of a self-insurers group.

When required:

Must be filed with the Agency after the employer has been accepted as a member into a self-insurers group.

General Guidelines for Filing Form WC-650:

(a) A Form WC-650 is a continuous filing. A form WC-651, Notice of Termination of Membership, only needs to be filed when terminating membership for an employer, if there is a name change, or if an entity of the employer has been sold or is out of business.
(b) If a new entity is to be added to an existing membership, a Form WC-650 must be filed which shows the additional business name, Federal ID Number, the Michigan address, etc. Do not file a Form WC-651 in this situation.
(c) If there are only address changes, a letter should be sent to the Agency identifying the business name, the owner name, the Federal ID Number of the employer, the addresses to be added or deleted, and the effective date for each address change. Form WC-650's and Form WC-651's should not be filed for address changes.

INSTRUCTIONS FOR COMPLETION

Item #1 — Employer's Federal Identification Number
Enter the employer's Federal Identification Number. This is a nine digit number. If an individual (sole proprietor) does not have a Federal Identification Number, the Social Security Number of the individual will be accepted. A Federal ID number or a Social Security Number is required on all Form WC-650 filings.

Item #2 — Name of Business
Enter the complete names of all the businesses including all assumed names (even if the names are not registered) and division names which operate under the same Federal ID Number listed in item #1.

Additional assumed names or division names operating under the same Federal ID Number should be listed in item #13 on the lower portion of this form. If there are more than four additional names, another Form WC-650 must be completed. Do not place additional business or division names on the back of the Form WC-650.

Separate Form WC-650's must be filed for each business which has a different Federal ID Number.

Item #3 — Owner Name
List the complete name of the corporation, partnership, individual, public employer, or joint venture which owns the business. If item #2 is identical to item #3, leave item #3 blank.

Item #4 — Business Address
The complete address of the business, including city, state and zip code, must be identified. Use street addresses, **not** post office box numbers. Additional Michigan addresses should be placed in item #13. If there are more than four additional addresses, they should be placed on an attached sheet which clearly identifies the Federal ID Number, name of business, and owner of the business.

Item #5 — Type of Organization
State whether the employer is a corporation, partnership, individual, public employer, or joint venture.

Item #6 — Self-Insured ID Number
Enter 8 digit Agency assigned group self-insured ID number and 3 digit service company ID number, if applicable.

Item #7 — Name of Group Fund
The full name of the group fund.

Item #8 — Effective Date of Coverage
Date coverage is effective. Numeric (month/day/year).

Item #9 — Annual Payroll in Dollars
Anticipated or actual annual payroll in dollars for the employer.

Item #10 — Michigan Class Code
Use class code found in the Michigan Workers' Compensation Statistical Plan which shows the highest amount of payroll (other than standard exceptions).

Item #11 — Number of Employees
Enter the number of employees for employer who are employed in Michigan.

Item #12 —Signature of Administrator or Trustee
Must have an original signature in black or blue ink. Typed signatures are not acceptable. Include the date the form was signed.

Item #13 — Additional Names and/or Addresses of the Business
See item #2 and item #4 for instructions.

Authority:	Workers' Disability Compensation Act 418.611(2); R408.43g(3)
Completion:	Mandatory
Penalty:	Failure to file is punishable under R408.43(h)(2)